MANAGED CARE CHECKLIST:
REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS
LICENSED UNDER M.G.L. c. 176G

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:
Pursuant to Bulletin 2001-05, please include a completed checklist for each evidence of coverage when submitting (1) an application for accreditation; (2) a material change to accreditation; (3) an application for an insured preferred provider plan; or (4) a material change to an insured preferred provider plan.

All material changes should include a red-line version of the previously filed document(s).

When completing this checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.

- ***For items requiring carrier confirmation, please place a checkmark (√) next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable, please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.***

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____

Product Name & Form #: _____

Date Submitted: _____

FLINGS THAT DO NOT INCLUDE ALL APPLICABLE FULLY COMPLETED CHECKLISTS WILL BE RETURNED AND NOT REVIEWED.

Carrier Certification:
I _____ a duly authorized representative of _____ certify that it is my good faith belief based on the review of this checklist and submitted evidence of coverage and additional materials that the evidence of coverage and additional submitted materials comply with applicable Massachusetts law.

FOR DIVISION OF INSURANCE USE ONLY
Date Received: _____
Reviewed by: _____

PORTABILITY OF HEALTH INSURANCE [M.G.L. c. 176N §1]

_____ **Health plan** "any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a group medical service plan issued by a non profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; provided, however, "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which under this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy under chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan under this chapter and shall be governed by said chapter 15A and the regulations promulgated hereunder."

_____ **Late enrollee** "an eligible employee or dependent who requests enrollment in a group health plan or insurance arrangement after the plan initial enrollment period, their initial eligibility date provided under the terms of the plan or arrangement or the group's annual open enrollment period; provided, however, that an insured shall not be considered a late enrollee if the request for enrollment to the insurer is made within 30 days after termination of coverage provided under another health insurance plan or arrangement where such coverage has ceased due to termination of the spouse's employment or death of the spouse or if the request for enrollment is made pursuant to section 9A, 9C or 18 of chapter 118E."

_____ **Waiting period** "a specified period immediately subsequent to the effective date of an eligible insured's coverage under the health plan or out of state health plan during which the plan does not pay for some or all medical expenses."

STANDARDS FOR PORTABILITY OF HEALTH INSURANCE [M.G.L. c. 176N §1]

According to M.G.L. c. 176N §2, "[n]o health plan shall:

"[e]xclude any eligible insured on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition of such person.

_____ **(M.G.L. c. 176N § 2(a)**

"[c]ontain a preexisting conditions provision that excludes coverage for a period beyond 6 months after the individual's date of enrollment. A preexisting conditions provision may only relate to: (1) conditions which had, during the 6 months immediately before the date of enrollment, manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received. In determining whether a preexisting conditions provision applies to an eligible insured, a health plan shall credit the time a person was under a previous qualifying health plan if the previous coverage was continuous to a date not more than 63 days before the effective date of the new coverage, exclusive of any applicable service waiting period under the new coverage and if the previous qualifying health

_____ plan coverage was reasonably actuarially equivalent to the new coverage; **(M.G.L. c. 176N §2(b)**

"[p]rovide for a waiting period of more than 4 months beyond the eligible insured's date of enrollment under the health plan, but an eligible individual who has not had creditable coverage for the 18 months before the date of enrollment shall not be subject to a waiting period. If a health plan includes a waiting period, emergency services shall be covered during the waiting period. The waiting period shall only apply to services which the new plan covers, but which were not covered under the old plan. In applying a waiting period to an eligible insured, a health plan shall credit the time the person was covered under a previous qualifying health plan if the

_____ person experiences only a temporary interruption in coverage; **(M.G.L. c. 176N §2(c)**

"[e]xclude late enrollees from coverage for more than twelve months from the date of the

_____ application for coverage of any late enrollee. **(M.G.L. c. 176N §2(d)**

"[i]n any circumstance in which more extensive coverage than that provided by clauses (a) to (d) is required by any other provision of the General Laws or any law of the United States, the health benefit plan shall satisfy such other provision insofar as it requires more extensive

_____ coverage. **(M.G.L. c. 176N §2(e)**

READABILITY OF POLICY FORM; DEFINITION; APPROVAL; ACTIONS BASED ON LANGUAGE - [M.G.L. CHAPTER 175 §2B]

Applies to policy forms, all certificates and subscription agreements or contracts of insurance issued pursuant to M.G.L. c. 176, c. 176A, c. 176B, c. 176G. Policyholder shall include, in addition to all insurance policyholders, all subscribers and holders of certificates issued pursuant to M.G.L. c. 176, c. 176A, c. 176B, c. 176G - ***M.G.L. c. 175 §2B. 2.***

Every policy form filed with the commissioner under this section shall be accompanied by a certificate stating the Flesch scale readability score achieved by such form(s).

_____ **[Statutory citation is stated within the certification]**

The term "text" as used in this section shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, captions and

_____ subcaptions, and schedule pages and tables.

No policy form of insurance shall be delivered or issued for delivery to more than fifty policyholders in the commonwealth until a copy of the policy form has been on file for thirty days with the commissioner, unless before the expiration of said thirty days the commissioner shall have approved the form of the policy in writing as complying with this section; nor shall any such policy be delivered or issued for delivery if the commissioner notifies the company in writing within said thirty days that in his opinion the form of said policy does not comply with the provisions of this section, specifying the reasons for his opinion, provided that such action of the commissioner shall be subject to review by the supreme judicial court, but during any such review the form shall not be delivered or issued for delivery in the commonwealth; nor shall any such policy form be so delivered or issued for delivery unless:

_____ The text achieves a minimum Flesch scale readability score of fifty; ***M.G.L. c. 175 §2B. 1.(a)***

_____ It is printed, except for tables, in not less than ten point type, one point leaded; ***M.G.L. c. 175 §2B. 1.(b)***

_____ The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy and any endorsements or riders; ***M.G.L. c. 175 §2B. 1.(c)***

_____ It contains a table of contents or an alphabetical subject index; ***M.G.L. c. 175 §2B. 1.(d)***

_____ The width of margins and ink to paper contrast do not unreasonably interfere with the readability of the form; and ***M.G.L. c. 175 §2B. 1.(e)***

_____ The organization of the content of the policy and the summary of the policy is conducive to understandability of the form. ***M.G.L. c. 175 §2B. 1.(f)***

_____ The certification identifies each form by form identifier and identifies the actual Flesch score for each form - **a statement to the effect that the score exceeds 50 is not permitted**.

For the purposes of this section, a Flesch scale readability score shall be measured as hereinafter provided:

_____ For policy forms containing ten thousand words or less of text, the entire form shall be analyzed. For policy forms containing more than ten thousand words, the readability of two two hundred word samples per page may be analyzed in lieu of the entire form. The samples shall be separated by at least twenty printed lines. ***M.G.L. c. 175 §2B 1.(1)***

_____ The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015. ***M.G.L. c. 175 §2B 1.(2)(a)(i)***

_____ The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6. ***M.G.L. c. 175 §2B 1.(2)(a)(ii)***

_____ The sum of the figures computed under subclause (i) and subclause (ii) subtracted from 206.835 equals the Flesch scale readability score for the policy form. ***M.G.L. c. 175 §2B 1.(2)(a)(iii)***

For the purposes of clause (a) the following procedures shall be used:

_____ A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word; ***M.G.L. c. 175 §2B 1.(2)(b)(i)***

_____ A unit of words ending with a period, semicolon, or colon, but excluding headings and captions shall be counted as a sentence; and ***M.G.L. c. 175 §2B 1.(2)(b)(ii)***

_____ A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used. ***M.G.L. c. 175 §2B 1.(2)(b)(iii)***

DESCRIPTION OF STANDARD HMO SERVICES

[M.G.L. c. 176G §1 and 211 CMR 43.00]

Description of services should be identified within the policy forms – identify the page number for each identified "health service."

Health Services at least reasonably comprehensive inpatient, outpatient, and emergency care services including: preventive services, such as:

_____ immunizations;
_____ periodic health exams for adults;
_____ prenatal maternity care;
_____ well child care including vision and auditory screening;
_____ voluntary family planning;
_____ nutrition counseling, and health education;
_____ pediatric care;
_____ minimum of 100 days in a 12-month period or 365 lifetime days of noncustodial care in a skilled nursing facility; and
_____ which may include, but not be limited to chiropractic services; optometric services; and podiatric services.

DEFINITIONS MANAGED CARE [M.G.L. c. 176O §1 and 211 CMR 52.03 (if used)]:

_____ **Adverse determination** "a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness."

_____ **Emergency medical condition** "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B)."

_____ **Medical necessity or medically necessary** "health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence."

_____ **Participating provider** "a provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier, including a dental or vision carrier."

_____ **Utilization review** "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review."

STANDARDS FOR UTILIZATION REVIEW [See also Bulletin Nos. 03-05, 02-04 and 01-10]:

According to 211 CMR 52.13(3)(o), evidences of coverage shall contain a summary description of utilization review procedures as follows:

According to 211 CMR 52.08(4), "[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information.

_____ (a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

_____ (b) In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter.

_____ (c) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter."

According to 211 CMR 52.08(5), "[a] carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information.

_____ (a) In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

_____ (b) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the insured and the provider within one working day thereafter.

_____ (c) The service shall be continued without liability to the insured until the insured has been notified of the determination."

According to 211 CMR 52.08(6), "[t]he written notification of an adverse determination shall include a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

_____ (a) identify the specific information upon which the adverse determination was based;

_____ (b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

_____ (c) specify any alternative treatment option offered by the carrier, if any;

_____ (d) reference and include applicable clinical practice guidelines and review criteria; and

_____ (e) include a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400."

Please (1) confirm that all carrier adverse determination letters meet the standards of M.G.L. c. 176O & regulations 211 CMR 52.00 and 105 CMR 128.000, (3) identify the date that such letters were filed for review or (3) if not filed, forward copies for review.

According to 211 CMR 52.08(7), "[a] carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination.

_____ (a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one working day.

_____ (b) If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to 105 CMR 128.000.

The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to
_____ the internal grievance process or an expedited appeal required by 105 CMR 128.000."

According to 211 CMR 52.08(10), "[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.

(b) Carriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds."

_____ **Please submit a copy of the most recent survey instrument and results.**

REQUIREMENTS OF PROVIDER CONTRACTS:

Please complete and submit the Managed Care: Provider Contracts checklist.

REQUIREMENTS OF AN EVIDENCE OF COVERAGE [M.G.L. c. 176O §6 and 211 CMR 52.13]:

(1) According to 211 CMR 52.13(3)(a)-(y) "[a] carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment, an evidence of coverage. The evidence of coverage shall contain a clear, concise and complete statement of:

_____

_____ (a) the health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law; **[See Mandated Benefits section below]]**

_____ (b) the prepaid fee which must be paid by or on behalf of the insured and an explanation of any grace period for the payment of any health benefit plan premium;

_____ (c) the limitations on the scope of health, dental or vision care services and any other benefits to be provided, including an explanation of any deductible or copayment feature;

_____ (d) all restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health, dental or vision benefit plan;

_____ (e) the locations where, and the manner in which, health, dental or vision care services and other benefits may be obtained;

_____ (f) a description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;

_____ (g) the criteria by which an insured may be disenrolled or denied enrollment. This provision shall apply to carriers, including dental and vision carriers;

_____ (h) the involuntary disenrollment rate among insureds of the carrier. This provision shall apply to carriers, including dental and vision carriers;

1. For the purposes of 211 CMR 52.13(3)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
2. For the purposes of 211 CMR 52.13(3)(h), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured

due to any of the reasons contained in 211 CMR 52.13(3)(i)2 and 3.

_____ (i) the requirement that an insured's coverage may be canceled, or its renewal refused, may arise only in the circumstances below. This provision shall apply to carriers, including dental and vision carriers:

_____ 1. failure by the insured or other responsible party to make payments required under the contract;

_____ 2. misrepresentation or fraud on the part of the insured;

_____ 3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3;

_____ 4. relocation of the insured outside the service area of the carrier; or

_____ 5. non-renewal or cancellation of the group contract through which the insured receives coverage;

_____ (j) a description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416;

_____ (k) a statement telling insureds how to obtain the report regarding grievances pursuant to 105 CMR 128.600(A)(4) from the Office of Patient Protection;

_____ (l) a description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;

_____ (m) a description of the carrier's, including a dental or vision carrier's, method for resolving insured inquiries and complaints;

_____ (n) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers. This provision shall apply to carriers, including dental and vision carriers;

_____ (o) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including a dental or vision carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions; [See Standards for Utilization Review above]

_____ (p) a statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish. This provision shall apply to carriers, including dental and vision carriers;

_____ (q) a list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the carrier does all of the following:

_____

a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;

b. clearly states that all other prescription drugs are excluded;

c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and

d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

(r) a summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(s) requirements for continuation of coverage mandated by state and federal law **[See Continuation of Coverage section below]**;

(t) a description of coordination of benefits consistent with 211 CMR 38.00;

(u) a description of coverage for emergency care and a statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(v) If the carrier offers services through a network or through participating providers, the following statements regarding continued treatment:

1. If the carrier allows or requires the designation of a primary care physician, a statement that the carrier will notify an insured at least 30 days before the disenrollment of such insured's primary care physician and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care physician for at least 30 days after said physician is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative primary care physician.

2. A statement that the carrier will allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

3. A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

4. A statement that the carrier will provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network if:

a. the insured's employer only offers the insured a choice of carriers in which said physician is not a participating provider, and

b. said physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician.

c. With respect to an insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

5. A carrier may condition coverage of continued treatment by a provider under 211 CMR 52.13(3)(v)1 through 52.13(3)(v)4, inclusive, upon the provider's agreeing as follows:

a. to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;

b. to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

c. to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier.

6. Nothing in 211 CMR 52.13(3)(v) shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(w) If a carrier requires an insured to designate a primary care physician, a statement that the carrier will allow the primary care physician to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when:

1. the primary care physician determines that such referrals are appropriate,

2. the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis, and

3. the health care services to be provided are consistent with the terms of the evidence of coverage.

4. Nothing in 211 CMR 52.13(3)(w) shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(x) If a carrier requires an insured to obtain referrals or prior authorization from a primary care physician for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care physician for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network and that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician:

1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination;

_____ 2. maternity care; and

_____ 3. medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.

_____ 4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an insured's primary care physician regarding the insured's condition, treatment, and need for follow-up care.

_____ 5. Nothing in 211 CMR 52.13(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

_____ A statement that the carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(3)(y), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services."

MINIMUM CREDITABLE COVERAGE NOTICES – (BULLETIN 2008-02)

As of January 1, 2009, the Massachusetts Health Care Reform Law requires each Massachusetts resident, eighteen (18) years of age and older, to have health coverage that meets the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector ("Connector"), unless those plans meeting these standards are deemed to not be affordable to that person.

In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate...all commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (collectively "carriers") that offer or renew an individual or group insured health plan in Massachusetts, as defined in M.G.L. c. 176N, with coverage effective on or after February 1, 2008...are to disclose to insureds and potential insureds a plan's MCC status and whether the plan satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law.

The insured health plan's MCC status will be based on compliance with applicable standards in effect on and after January 1, 2009 as set forth by the Connector either by regulation or administrative bulletin.

_____ In the case of an employer-sponsored group insured health plan, said disclosure requirement also applies to marketing materials that describe the insured health plan benefits that are used during the employer's open enrollment period.

Please confirm that the carrier complies with this requirement.

_____ The filed product **meets MCC standards**;

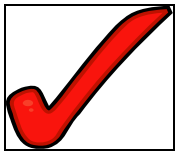
_____ The filed product **does not meet MCC standards**;

_____ The filed product **is not considered a "health plan", as defined in M.G.L. c. 176N**.

Please place a checkmark (√) next to the statement indicating whether the filed plan product design is sufficient to satisfy the Minimum Creditable Coverage ("MCC") standards set by the Commonwealth Health Insurance Connector.

IF THE INSURED HEALTH PLAN MEETS MCC STANDARDS:

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format: :



This health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2009 *(carriers are to substitute applicable date)* as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009 *(carriers are to substitute applicable date)*. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

IF THE INSURED HEALTH PLAN DOES NOT MEET MCC STANDARDS

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format: :

This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan, alone, **does not meet Minimum Creditable Coverage standards** that are effective January 1, 2009 *(carriers are to substitute applicable date)* as part of the Massachusetts Health Care Reform Law because *(carriers are to substitute applicable minimum creditable coverage standards as set by the Connector)*:

- ☐ The in-network deductible is more than $2,000 for an individual and/or $4,000 for a family.
- ☐ A broad range of medical benefits, as defined by the Connector, are not covered.
- ☐ Prescription drugs are not covered.
- ☐ The deductible for prescription drug coverage is more than $250 for an individual and/or $500 for a family.
- ☐ The health plan includes deductibles or coinsurance for in-network core services, but does not include an out-of-pocket maximum.
- ☐ The health plan includes deductibles or coinsurance for in-network core services, but the out-of-pocket maximum is more than $5,000 for an individual and/or $10,000 for a family.

- ☐ The health plan includes deductibles or coinsurance for in-network core services, but the out-of-pocket maximum does not include one or more of the following for in-network services: copayments over $100, coinsurance, or deductibles.

- ☐ The health plan imposes an overall annual maximum benefit or a per illness annual maximum benefit for covered core services.

- ☐ A fee schedule is imposed on indemnity benefits for in-network covered services.

- ☐ The deductible for in-network benefits does not exclude the required minimum of three preventive care visits for individual coverage and six preventive care visits for all other coverage types (i.e., two-person, individual plus child, family).

If you purchase this health plan only, you **will not satisfy** the statutory requirement that you have health insurance meeting these standards.

If this health plan is offered to you through your place of employment, contact your employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your employer or other plan sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.

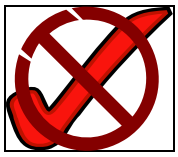
If this health plan is not offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009 *(carriers are to substitute applicable date)*. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

IF AN INSURED ACCIDENT AND SICKNESS PLAN IS NOT CONSIDERED A "HEALTH PLAN", AS DEFINED IN M.G.L. C. 176N

_____ The following disclosure notice must be included on the face or the first page of the text of the policy or certificate or on any required notice submitted with the product in substantially the same language and format: :



This health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. Please see page # for additional information.

_____ In addition, the following disclosure shall be placed within the body of the policy, certificate, or schedule of benefits in substantially the same language and format:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Internet websites - 211 CMR 52.13(4)

If the carrier, including any dental or vision carrier, refers the insured to resources where the information described in the evidence of coverage can be accessed, including, but not limited to, an internet website, such carrier must be able to demonstrate compliance with the following with respect to the internet website, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The carrier has issued and delivered written notice to the insured that includes:

_____ 1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;

_____ 2. A list of the specific information to be furnished by the carrier through an internet website;

_____ 3. The significance of such information to the insured;

_____ 4. The insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;

_____ 5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and

_____ 6. A toll-free number for the insured to call with any questions or requests.

_____ (b) The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to evidences of coverage shall apply to information and documents furnished by an internet website.

_____ (c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.

_____ According to 211 CMR 52.13(5), "[a] carrier, including a dental and vision carrier, shall always deliver at least one evidence of coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 211 CMR 52.14, or 211 CMR 52.15."

_____ According to 211 CMR 52.13(6), "[a] carrier, including a dental and vision carrier, shall provide to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all material changes to the evidence of coverage.
Please confirm that the carrier will comply with this requirement.

_____ According to 211 CMR 52.13(7), "[a] carrier, including a dental or vision carrier, shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health, dental or vision plan, at least 60 days before the effective date of the modifications. Such notices shall include the following:

_____ (a) any changes in clinical review criteria; and

_____ (b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

_____ According to 211 CMR 52.13(8), "[a] carrier, including a dental or vision carrier, shall submit

all evidences of coverage to the Bureau at least 30 days prior to their effective dates.
Please confirm that the carrier will comply with this requirement.

_____ According to 211 CMR 52.13(9), "[c]arriers, including dental or vision carriers, may use evidences of coverage issued prior to 90 days after the effective date of the regulation as if in compliance with 211 CMR 52.13. Evidences of coverage issued or renewed on or after 90 days after the effective date of the regulation [March 3, 2006] must comply with all of the requirements of 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13.
Please confirm that the carrier will comply with this requirement.

_____ According to 211 CMR 52.13(10), "[e]very evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

PROMPT PAYMENT

_____ According to M.G.L. c. 176G §6, "No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the provider of health care services, the health maintenance organization shall (i) make payments for such services provided, (ii) notify the provide in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the health maintenance organization fails to comply with this paragraph for any claims related to the provision of health care services, said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the health maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the health maintenance organization is investigating because of suspected fraud. No contract between a participating home health agency or a participating licensed hospice agency and a health maintenance organization shall be issued or delivered in the commonwealth that requires the participating home health agency or participating licensed hospice agency to be accredited by the Joint Commission on Accreditation of Healthcare Organizations or other national accrediting body if it is certified for participation in the Medicare program, Title XVIII of the federal Social Security Act, 42 U.S.C. Sections 1395 et seq.." (See also M.G.L. c. 176A, § 8(e) – must be in contract between subscriber and corporation; M.G.L. c. 176B, § 7; M.G.L. c. 175, § 110(G) and Bulletin No. 00-13)

REQUIRED DISCLOSURES

According to 211 CMR 52.14(1)(a)-(e), "[a] carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

_____ (a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in
_____ Massachusetts;

(b) a summary description of the process by which clinical guidelines and utilization
_____ review criteria are developed;

(c) the voluntary and involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.

3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary

disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2 and 3.

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

_____ 1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

_____ 2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

_____ 3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and

_____ 4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

_____ (e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the insured or prospective insured from the Office of Patient Protection."

_____ According to 211 CMR 52.14(3), "[e]very disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date."

_____ According to 211 CMR 52.14(4) and (5), "[c]arriers shall submit material changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 days before their effective dates" [and] "to at least one adult insured in every household residing in Massachusetts at least once every two years." **Please confirm that the carrier will comply with this requirement.**

REQUIREMENTS FOR PROVIDER DIRECTORIES [211 CMR 52.15]

_____ According to 211 CMR 52.15(1)(a)-(d), "[a] carrier shall deliver a provider directory to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request.

_____ Annually, thereafter, a carrier shall deliver to at least one adult insured in each household, or in the case of a group policy, to the group representative, a provider directory. The carrier may deliver a provider directory through an internet website. References to the term "internet website" shall include intranet websites and electronic mail, or "e-mail".

_____ (a) The provider directory must contain a list of health care providers in the carrier's network available to insureds residing in Massachusetts, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider.

_____ 1. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific

details of any financial arrangements between a carrier and a provider.

_____ 2. A carrier will be deemed to be in compliance with 211 CMR 52.15(1)(a) if the method of compensation is identified at least as specifically as "fee-for service" or "capitation."

_____ 3. If any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

_____ (b) The provider directory must contain a toll-free number that insureds can call to determine whether a particular health care provider is affiliated with the carrier.

_____ (c) The provider directory must contain an internet website address or link that insureds can visit to determine whether a particular provider is affiliated with the carrier.

(d) If the carrier refers an insured to access provider directory information through an internet website, the carrier must be able to demonstrate compliance with the following:

_____ 1. The carrier has issued and delivered written notice to the insured that includes:

_____ (a) All necessary information and a clear explanation of the manner by which insureds can access their specific provider directory through an internet website;

_____ (b) A list of the specific information to be furnished by the carrier through an internet website;

_____ (c) The significance of such information to the insured;

_____ (d) The insured's right to receive, free of charge, a paper copy of the provider directory at any time;

_____ (e) The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and

_____ (f) A toll-free number for the insured to call with any questions or requests.

_____ 2. The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents.

_____ 3. All notice and time requirements applicable to evidences of coverage shall apply to information and documents made available by Internet.

_____ (a) Information contained in the documents furnished in an internet website shall include the effective date and the published date of any updates, modifications or material changes.

_____ 4. The carrier updates the website as soon as practicable.

_____ 5. In the case of a group policy, the carrier delivers a paper copy of the provider directory to the group representative.

_____ 6. The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of the provider directory. Forward sample copy of website address and documents appearing on its website.

According to 211 CMR 52.15(2), "[c]arriers that delivered provider directories prior to January 1, 2001 shall be deemed to have met the requirements of 211 CMR 52.15(1) if during the year between July 1, 2001 and June 30, 2002 the carrier delivers a provider directory to at least one adult insured in each household and to any new enrollee on or after July 1, 2001.

_____ **Please confirm that the carrier complies with these requirements.**

According to 211 CMR 52.15(3), "[a] carrier shall not be required to deliver a provider directory upon enrollment if a provider directory is delivered to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

_____ **Please explain how the carrier complies with this requirement.**

According to 211 CMR 52.15(4) "[i]f delivering a paper copy of the provider directory, a carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the carrier:

_____ (a) provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.15(1); and

_____ (b) updates its toll-free number within 48 hours and internet website as soon as practicable.

_____ According to 211 CMR 52.15(5), "[e]very provider directory described in 211 CMR 52.15 must contain the effective date, date of issue and expiration date if applicable.

_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to:

1) confirm that the carrier monitors its network of providers;
2) confirm whether the carrier's network includes network providers that require patients to pay an annual fee as a condition for inclusion within that provider's panel of patients
3) if the network includes such providers, confirm that the carrier has amended its provider directory(ies) to clearly identify those providers that will be unavailable to its members who do not or cannot pay the annual fee to be part of the providers' panel and highlight the page(s) that such information may be located within the directory(ies);"
4) Include with the filing a document that lists those contracted providers that charge an annual fee to members as a condition to continue to be a part of the providers' panel of patients.
5) Confirm that the carrier will continue to monitor its network and will advise the Division as necessary regarding contracted providers that charge an annual fee as described above.

Please include a statement within the filing that addresses each noted item above to consider the filing complete.

As noted in Bulletin No. 02-07, in meeting the provisions of Chapter 80 of the Acts of 2000 ("Chapter 80"), carriers are to provide or arrange for the "full range of mandated services, including specific treatment modalities appropriate for all ages of patients and all types of

covered mental conditions." In addition, it is noted that carriers are to have "sufficient numbers of providers available in the network so that no patient must wait a medically inappropriate amount of time to receive care for acute conditions" and that "care is being delivered promptly and appropriately and that insureds are being provided adequate access as required by law." In order to satisfy the provisions of Chapter 80 and Bulletin No. 02-07, it would appear that provider directories should include lists that address at least the following types of behavioral health providers:

_____ (a) general behavioral health providers;
_____ (b) child/pediatric and adolescent behavioral health providers;
_____ (c) geriatric behavioral health providers;
_____ (d) substance abuse providers or addictionologists; and
_____ (e) eating disorder specialists.

Please make sure to note the page numbers where the above-noted providers are listed within the provider directory.

_____ According to Chapter 80, carriers are required to provide or arrange for "a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting . . . inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, or a professional office, or through home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his [or her] license."

_____ Consistent with the requirements of 211 CMR 52.15(1)(a), indicate next to each provider in the directory their professional licensure designation(s) and clarify with footnotes or other prominent notes whether providers are or are not taking new patients and if they only see patients in certain settings (for example, in an inpatient or intermediate care setting).

DEPENDENT ELIGIBILITY

_____ According to M.G.L. c. 176G §4T, "[a] health maintenance contract, excluding contracts for stand-alone dental services, shall provide coverage to persons under 26 years of age or for 2 years after the end of the calendar year in which such persons last qualified as dependents under 26 U.S.C. 106, whichever occurs first.

CONTINUATION OF COVERAGE PROVISIONS

According to 211 CMR 52.13(3)(s), evidences of coverage shall contain a clear, concise and complete statement of the requirements for continuation of coverage mandated by state and federal law as follows:

_____ **Plant Closing** According to M.G.L. c. 176G, § 4A, there is a 90-day eligibility for continued coverage in the event of a plant closing or partial plant closing.

Divorce or Separation According to M.G.L. c. 176G, § 5A(a)-(b),

_____ "(a) In the event of the granting of a judgment absolute of divorce or of separate support to which a member of a group health maintenance contract is a party, the person who was the spouse of said member prior to the issuance of such judgment shall be and remain eligible for benefits under said contract, whether or not said judgment was entered prior to the effective date of said contract, without additional premium or examination therefor, as if said judgment had not been entered; provided, however, that such eligibility shall not be required if said judgment so provides. Such eligibility shall continue through the member's participation in the contract until the remarriage of either the member or such spouse, or until such time as provided by said judgment, whichever is earlier.

_____ (b) In the event of the remarriage of the member referred to in paragraph (a), the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family contract or the issuance of an individual contract, either of which may be at additional premium rates determined by the commissioner of insurance to be just and reasonable in accordance with the additional insuring risks involved."

_____ **Small Group**. There must be a provision for continuation of coverage for any individual, general, blanket or group policy of health, accident and sickness insurance ***(excludes supplements to Medicare or other governmental programs)*** if sold to an eligible small business or group with between 2-19 employees and the provisions for continuation of coverage should be in compliance with M.G.L. c. 176J, § 9.

_____ **Group Health Care Insurers.** According to 940 CMR 9.04, it shall be considered an unfair and deceptive act or practice in violation of M.G.L. c. 93A, § 2, for a carrier to deny a member's claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the member prior to the date the covered health care services were received in the manner set forth in 940 CMR 9.05.

MANDATED BENEFITS

According to 211 CMR 52.13(3)(a), evidences of coverage shall contain a clear, concise and complete statement of the health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law as follows:

Requirements for emergency services provided to members for emergency medical conditions

_____ According to M.G.L. c. 176G, § 5(b), "[a] health maintenance organization shall cover emergency services provided to members for emergency medical conditions. After the member has been stabilized for discharge or transfer, the health maintenance organization or its designee may require a hospital emergency department to contact the physician on-call designated by the health maintenance organization or its designee for authorization of post-stabilization services to be provided. The hospital emergency department shall take all reasonable steps to initiate contact with the health maintenance organization or its designee within 30 minutes of stabilization. Such authorization shall be deemed granted if the health maintenance organization or its designee has not responded to said call within 30 minutes…in the event the attending physician and said on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition provided that such treatment is consistent with generally accepted principles of professional medical practice and a covered benefit under the member's evidence of coverage." (See also Bulletin No. 00-14)

_____ According to M.G.L. c. 176G, § 5(c), "[a] health maintenance organization may require a member to contact either the health maintenance organization or its designee or the primary care physician of the member within 48 hours of receiving such emergency services, but notification already given to the health maintenance organization or to said primary care physician by the attending physician shall satisfy the requirements of this paragraph."

_____ According to M.G.L. c. 176G, § 5(e), "[a] health maintenance organization shall clearly state in its brochures, contracts, policy manuals and printed materials that members shall have the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever an enrollee is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services. No member shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of an emergency medical condition."

Mental Health Parity

_____ **Biologically Based Mental Disorders**. According to M.G.L. c. 176G, § 4M(a), "[a] health maintenance contract issued or renewed within or without the commonwealth shall provide mental health benefits on a nondiscriminatory basis to residents of the commonwealth and to all members or enrollees having a principal place of employment in the commonwealth for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this section as ""the DSM": (1) schizophrenia, (2) schizoaffective disorder, (3) major depressive disorder, (4) bipolar disorder, (5) paranoia and other psychotic disorders, (6) obsessive-compulsive disorder, (7) panic disorder, (8) delirium and dementia, (9)

affective disorders, and (10) any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance."

_____ **Rape-Related Mental or Emotional Disorders**. According to M.G.L. c. 176G, § 4M(b), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265 [of the Massachusetts General Laws], whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C [of the Massachusetts General Laws]."

_____ **Children and Adolescents under the age of 19**. According to M.G.L. c. 176G, § 4M(c), "any such health maintenance contract shall also provide benefits on a non-discriminatory basis to children and adolescents under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care physician, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (1) an inability to attend school as a result of such a disorder, (2) the need to hospitalize the child or adolescent as a result of such a disorder, (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. The health maintenance organization shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent's nineteenth birthday until said course of treatment, as specified in said adolescent's treatment plan, is completed and while the benefit contract under which such benefits first became available remains in effect, or subject to a subsequent benefits contract which is in effect."

_____ According to Bulletin No. 00-10, "[c]arriers must . . . continue to provide non-discriminatory mental health benefits . . . to any such adolescent who continues coverage under any other subsequent contract. Relative to a carrier's responsibility to continue to provide the mandated benefit for such an adolescent when he/she turns 19 and, in certain cases, ceases to qualify as a dependent under his/her parent's health plan, carriers must continue to provide the mandated mental health benefits. In this case, carriers may charge the affected person his/her usual premium in order to qualify for the continuation of this mandated benefit or offer the person the option to pay for continuation of the health plan coverage under federal (COBRA) or state continuation provisions. . . . [T]he Division suggests that carriers make clear that if COBRA coverage is selected then all plan benefits will be available. If COBRA coverage is not selected, any premium paid to continue the mental health benefits beyond age 19 will continue Chapter 80 benefits only and COBRA eligibility will not be extended."

_____ **Parity**. According to M.G.L. c. 176G, § 4M(d), "[a]ny such health maintenance contract shall be deemed to be providing such coverage on a non-discriminatory basis if the health maintenance contract does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any

annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions."

_____ **All Other Mental Disorders**. According to M.G.L. c. 176G, § 4M(e), "[a]ny such health maintenance contract shall also provide benefits for the diagnosis and treatment of all other mental disorders not otherwise provided for in this section and which are described in the most recent edition of the DSM during each 12 month period for a minimum of 60 days of inpatient treatment and for a minimum of 24 outpatient visits."

_____ According to Bulletin No. 00-10, "[a]lthough these other mandated mental health benefits can be capped according to the number of days of inpatient treatment or outpatient visits, no other limitations, coinsurance, copayment, deductibles or other cost-sharing may be applied toward these benefits except as are applied to covered medical services within the plan."

_____ **Psychopharmacological Services and Neuropsychological Assessment Services.** According to M.G.L. c. 176G, § 4M(i), "psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services."

_____ **Mental Health Related Alcohol and Chemical Dependency Treatment *(Except a policy which provides supplemental coverage to Medicare or other governmental programs)*** According to M.G.L. c. 176G, § 4M(f), "[t]he limitation on benefits for the treatment of alcoholism or chemical dependency established by subdivision (H) of section 110 of chapter 175 and by section 4 [of the Massachusetts General Laws] shall not apply when said treatment is rendered in conjunction with treatment for mental disorders pursuant to this section nor shall said limitation on benefits established by said subdivision (H) of said section 110 and by said section 4 [of the Massachusetts General Laws] impose or be construed to impose any restriction or limitation in connection with benefits for the treatment of mental disorders pursuant to this section."

_____ **Where Services may be Provided**. According to M.G.L. c. 176G, § 4M(g), "[b]enefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license." (See also Bulletin No. 03-11)

_____ **Disclosure**. According to M.G.L. c. 176G, § 4M(h), "[n]o health maintenance organization

shall require as a condition to receiving benefits mandated by this section consent to the disclosure of information regarding services for mental disorders under different terms and conditions than consent is required for disclosure of information for other medical conditions. A determination by a health maintenance organization that services authorized pursuant to this section are not medically necessary shall only be made by a licensed mental health professional; provided, that this provision shall not be construed as applying to denials of service resulting from an insured's lack of insurance coverage or use of a facility or professional which has not entered into a negotiated agreement with the health maintenance organization. The benefits provided in any health maintenance contract pursuant to this section shall meet all other terms and conditions of the health maintenance contract not inconsistent with this section."

General Provisions regarding Alcoholism (*limitations as set forth under M.G.L. c. 175, § 110(H)(a)-(b) except a policy which provides supplemental coverage to Medicare or other governmental programs)*

_____ **Inpatient**: Minimum of 30 days per calendar year in an **accredited or licensed hospital** or in **any other public or private facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics** and which is licensed by the Department of Public Health for those services, or in a **residential alcohol treatment program**. Notwithstanding the foregoing provisions, the period of confinement may be calculated by substituting, solely at the insurer's option and, where medically appropriate, two days of outpatient day treatment for one day of inpatient hospital care. "Outpatient hospital day" shall be defined by the division of insurance. (See also M.G.L. c. 176A, § 10, M.G.L. c. 176B, § 4A1/2, and Bulletin No. 97-04)

_____ **Outpatient**: Minimum of $500 over a 12-month period for services **furnished by an accredited or licensed hospital or any public or private facility** or portion thereof providing services especially **for the rehabilitation of intoxicated persons or alcoholic**s and which is licensed by the department of public health for those purposes. Consultants or treatment sessions furnished by a facility pursuant to M.G.L. c. 175 §110(H)(b) shall be rendered by a physician or psychotherapist fully licensed under the provisions of M.G.L. c. 112 who devotes a substantial portion of his time treating intoxicated persons or alcoholics. (See also M.G.L. c. 176A §10, M.G.L. c. 176B §4A1/2, and Bulletin No. 97-04)

Preventive and Primary Care Services for Children

_____ **Dependent Definition** According to M.G.L. c. 176G, § 4, a dependent includes "newborn infants and newborn infants of a dependent of a policyholder domiciled in the commonwealth . . . immediately from the moment of birth and thereafter . . . [and] adoptive children of a policyholder domiciled in the commonwealth . . . immediately from the date of the filing of a petition to adopt . . . and thereafter if the child has been residing in the home of the policyholder . . . as a foster child for whom the holder or beneficiary has been receiving foster care payments, or, in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of a policyholder . . . and thereafter."

_____ According to M.G.L. c. 176G, § 4, "[i]f payment of a specific premium is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or of filing of a petition to adopt a foster child or of placement of a child for purposes of adoption and payment of the required premium must be furnished to the insurer or indemnity corporation. For the purposes of this section "notification" may mean submission of a claim."

_____ According to M.G.L. c. 176G, § 4 "[t]he coverage for newly born infants and adoptive children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth."

_____ According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include those special medical formulas which are approved by the commissioner of the department of public health, prescribed by a physician, and are medically necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or medically necessary to protect the unborn fetuses of pregnant women with phenylketonuria."

_____ According to M.G.L. c. 176G, § 4 "[s]uch coverage [for newly born infants and adoptive children] shall also include screening for lead poisoning as required by the regulations promulgated pursuant to section one hundred and ninety-three of chapter one hundred and eleven [of the Massachusetts General Laws; 105 CMR 460.050]."

_____ According to M.G.L. c. 176G, § 4, policies must include coverage for the following services to the dependent child of an insured member from the date of birth through the attainment of six (6) years of age:

_____ "physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three (3) times during the next year, annually until age six."

_____ "Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematrocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician."

_____ According to M.G.L. c. 176G, § 4, policies shall provide "coverage for the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the department of public health." (See also Bulletin No. 98-13)

Early Intervention

_____ According to M.G.L. c. 176G, § 4, "[t]he dependent coverage of any such policy shall also provide coverage for medically necessary early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the department of public health and in accordance with applicable certification requirements. Such medically necessary services shall be provided by early intervention specialists who are working in early intervention programs certified by the department of public health, as provided in sections 1 and 2 of chapter 111G, for children from birth until their third birthday. Reimbursement of costs for such services shall be part of a basic benefits package offered by the insurer or a third party, with a maximum benefit of $5,200 per year per child and an aggregate benefit of $15,600 over the total enrollment period."

Maternity Coverage

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits . . . for the expense of prenatal care, childbirth and post partum care to the same extent as provided for medical conditions not related to pregnancy." (See also Bulletin Nos. 97-01 and 96-02)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide coverage of a minimum of forty-eight [48] hours of in-patient care following a vaginal delivery and a minimum of ninety-six [96] hours of in-patient care following a caesarean section for a mother and her newly born child. Any decision to shorten such minimum coverages shall be made by the attending physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the department of public health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery, and post-delivery care and shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a registered nurse, physician, or certified nurse midwife; and provided, further, that any subsequent home visit determined to be clinically necessary shall be provided by a licensed health care provider." (See also Bulletin Nos. 97-01 and 96-02)

_____ According to M.G.L. c. 176G, § 4, "[f]or the purposes of this section [M.G.L. c. 176G, § 4] attending physician shall include the attending obstetrician, pediatrician, or certified nurse midwife attending the mother and newly born child." (See also Bulletin Nos. 97-01 and 96-02)

Infertility Benefits

(Except a policy which provides supplemental coverage to Medicare or other governmental programs and Dioceses)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide, to the same extent that benefits are provided for other pregnancy-related procedures, coverage for medically necessary expenses of diagnosis and treatment of infertility to persons residing within the commonwealth . . . [and] 'infertility' shall mean the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year." (See also Bulletin No. 95-08)

According to 211 CMR 37.05, "[s]ubject to any reasonable limitations as described in 211 CMR 37.08, insurers shall provide benefits for all non-experimental infertility procedures including, but not limited to:

_____ (1) Artificial Insemination (AI);
_____ (2) In Vitro Fertilization and Embryo Placement (IVF-EP);
_____ (3) Gamete Intra fallopian Transfer (GIFT);
_____ (4) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
_____ (5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility;
_____ (6) Zygote Intrafallopian Transfer (ZIFT)."

_____ According to 211 CMR 37.06, "[I]nsurers shall not impose exclusions, limitations or other restrictions on coverage for infertility-related drugs that are different from those imposed on any other prescription drugs."

_____ According to 211 CMR 37.08(1), "[n]o insurer shall impose deductibles, copayments,

coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits which are different from those imposed upon benefits for services not related to infertility." **Please confirm that the carrier complies with this requirement.**

_____ According to 211 CMR 37.08(2), "[n]o insurer shall impose pre-existing condition exclusions or pre-existing condition waiting periods on coverage for required infertility benefits. No insurer shall use any prior diagnosis of or prior treatment for infertility as a basis for excluding, limiting or otherwise restricting the availability of coverage for required infertility benefits."

Hormone Replacement Therapy and Contraceptive Services
(Except contracts purchased by a subscriber that is a church or qualified church-controlled organization as those terms are defined in 26 U.S.C. section 3121(w)(3)(A) and (B))

_____ According to M.G.L. c. 176G, § 4O(a), "[a]ny individual or group health maintenance contract that is issued, renewed or delivered within or without the commonwealth and that provides benefits for outpatient services shall provide to residents of the commonwealth and to persons having a principal place of employment within the commonwealth benefits for hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services under the same terms and conditions as for such other outpatient services. Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration." (See also Bulletin No. 02-09)

_____ According to M.G.L. c. 176G, § 4O(b) "[a]ny individual or group health maintenance contract that is issued, renewed or delivered within or without the commonwealth and that provides benefits for outpatient prescription drugs or devices shall provide to residents of the commonwealth and to persons having a principal place of employment within the commonwealth benefits for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices that have been approved by the United States Food and Drug Administration under the same terms and conditions as for such other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods, nothing in this section precludes the use of closed or restricted formulary." (See also Bulletin No. 02-09)

Cytologic screening and mammographic examination expense benefits

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense…of cytologic screening and mammographic examination. Said benefits shall be at least equal to the following minimum requirements: (a) in the case of benefits for cytologic screening, said benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and (b), in the case of benefits for mammographic examination said benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for a mammogram on an annual basis for women forty years of age and older."

Bone Marrow Transplants for Breast Cancer

_____ According to M.G.L. c. 176G, § 4F, "[a]ny group health maintenance contract shall provide coverage for a bone marrow transplant or transplants for persons who have been diagnosed with

breast cancer that has progressed to metastatic disease; provided, however, that said person shall meet the criteria established by the department of public health [105 CMR 240.00]."

Federal Mastectomy Mandate

_____ According to the Women's Health and Cancer Rights Act of 1998, "[a] group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter."

Coverage for Human Leukocyte Antigen Testing for Certain Individuals and Patients
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4Q, policies shall provide coverage "for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish [such member's or enrollee's] bone marrow transplant donor suitability. The coverage shall cover the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health pursuant to section 218 of chapter 111 [of the Massachusetts General Laws]." (See also Bulletin Nos. 01-16 and 01-04)

Cardiac Rehabilitation Coverage
(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4, policies "shall provide benefits for the expense of cardiac rehabilitation. Cardiac rehabilitation shall mean multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting and which shall meet standards promulgated by the commissioner of public health after reviewing proposals submitted by the Massachusetts Society for Cardiac Rehabilitation, Inc. and after notice and public hearing on the proposed standards. Such standards shall include, but not be limited to, outpatient treatment which is to be initiated within twenty-six weeks after the diagnosis of such disease [105 CMR 143.00]."

Hospice Care

_____ According to M.G.L. c. 176G, § 4L, "[a]ny group health maintenance contract shall provide coverage for hospice services as defined in section 57D of chapter 111 [of the Massachusetts General Laws] during the life of the patient, to terminally ill patients with a life expectancy of six months or less; provided, however, that such services are determined to be appropriate and authorized by the patient's primary care or treating physician and are equivalent to those services provided by a licensed hospice program regulated by the department of public health

[105 CMR 141.00]."

Home Health Care Coverage

_____ According to M.G.L. c. 176G, §4C, ""Home care services", shall mean health care services for a patient provided by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy. Benefits for home care services shall apply only when such services are medically necessary and provided in conjunction with a physician approved home health services plan."

Speech, Hearing and Language Disorders

_____ According to M.G.L. c. 176G, § 4N, policies shall provide "for the expenses incurred in the medically necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists under [the provisions of] chapter 112 [of the Massachusetts General Laws], if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists regardless of whether the services are provided in a hospital, clinic or a private office, and if such coverage shall not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting. The benefits provided by this section shall be subject to the same terms and conditions established for any other medical condition covered by such individual or group health maintenance contract." (See also Bulletin No. 01-03)

Non-prescription Enteral Formulas for Home Use

_____ According to M.G.L. c. 176G, § 4D, "[a] group health maintenance contract shall provide coverage for nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein in an amount not to exceed two thousand five hundred dollars [2,500] annually for any insured individual." (See also Bulletin No. 95-09)

HIV and Hepatitis C Prevention

_____ According to M.G.L. c. 176G §4R, "[n]o individual or group health maintenance contract shall restrict or discontinue coverage for medically necessary hypodermic syringes or needles, notwithstanding section 27 of chapter 94C. The term "medical necessity" shall be construed in accordance with the guidelines set forth in subsection (b) of section 16 of chapter 176O."

_____ For plans that do not include a prescription drug benefit, the Division would consider it reasonable for carriers to require a copayment or coinsurance for a 30-day supply of hypodermic syringes or needles that is equal to the copayment or coinsurance required for a primary care

office visit. [See also Chapter 172 of the Acts of 2006]

Off-Label Use of Drugs for the treatment of Cancer and HIV/AIDS

_____ According to M.G.L. c. 176G, § 4E, no policy "shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the off-label use of the drug has not been approved by the United States Food and Drug Administration for that indication; provided, however, that such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven L [of chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug."

_____ According to M.G.L. c. 176G, § 4G, no policy "shall exclude coverage of any such drug for HIV/AIDS treatment on the grounds that the off-label use of the drug has not been approved by the federal food and drug administration for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section forty-seven P of [chapter 175 of the Massachusetts General Laws]. Any coverage of a drug required by this section shall also include medically necessary services associated with the administration of the drug." (See also Bulletin Nos. 97-09, 96-06, 96-05, and 95-05)

Diabetes Cost Reduction

(Except a policy which provides supplemental coverage to Medicare or other governmental programs)

_____ According to M.G.L. c. 176G, § 4H, policies shall provide "coverage for the following items if such items are within a category of benefits or services for which coverage is otherwise afforded by the contract, have been prescribed by a health care professional legally authorized to prescribe such items and if the items are medically necessary for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes: blood glucose monitors; blood glucose monitoring strips for home use; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; prescribed oral diabetes medications that influence blood sugar levels; laboratory tests, including glycosylated hemoglobin, or HbAlc, tests; urinary protein/microalbumin and lipid profiles; insulin pumps and insulin pump supplies; insulin pens, so-called; therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist; supplies and equipment approved by the Federal Drug Administration for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified diabetes health care provider participating with the health maintenance contract or affiliated with a provider participating with the health maintenance contract."

According to Bulletin No. 00-05, "nondiscriminatory treatment of benefits for diabetes-related services is mandated. The Division will consider a carrier to be in compliance . . . if the mandated services and supplies are covered within the following categories of benefits:

_____ • **outpatient services**: outpatient diabetes self-management training and education;

_____ • **laboratory/radiological services**: all laboratory tests and urinary profiles;
_____ • **durable medical equipment**: blood glucose monitors, voice-synthesizers and visual magnifying aids;
_____ • **prosthetics**: therapeutic/molded shoes and shoe inserts; and
_____ • **prescription drugs**: blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications.

_____ For items in the last category, with the exception of an insulin pump, the Division will consider a carrier to be in compliance if a co-payment is applied for no less than a 30-day supply of the mandated item. The Division will consider it to be a violation . . . if a carrier excludes from a particular category any of the above-noted items for diabetics."

Coverage For Certain Prosthetic Devices

_____ According to M.G.L. c. 176G, § 4S(a), "[i]ndividual and group health maintenance contracts shall provide coverage for prosthetic devices and repairs. If prosthetic devices are covered as a durable medical equipment benefit, coverage shall be provided under the same terms and conditions that apply to other durable medical equipment covered under the contracts, except as otherwise provided in this section. If prosthetic devices are covered as a stand-alone prosthetic benefit, coverage shall be consistent with the terms and conditions as described in this section."

_____ (b) In this section, "prosthetic device" shall mean an artificial limb device to replace, in whole or in part, an arm or leg.

_____ (c) A health maintenance contract shall not impose any annual or lifetime dollar maximum on coverage for prosthetic devices other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract.

_____ (d) A health maintenance contract shall not apply amounts paid for prosthetic devices to any annual or lifetime dollar maximum applicable to other durable medical equipment covered under the contract other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the contract.

_____ (e) A health maintenance contract may include a reasonable coinsurance requirement for prosthetic devices and repairs, not to exceed 20 per cent of the allowable cost of the prosthetic device or repair, unless all covered benefits applying coinsurance under the plan do so at a higher amount. If the health maintenance contract provides coverage for services from nonparticipating providers, the contract may include a reasonable coinsurance requirement for prosthetic devices and repairs, not to exceed 40 per cent of the allowable cost of the prosthetic device or repair when obtained from a nonparticipating provider, unless all covered benefits applying coinsurance under the plan do so at a higher amount.

_____ (f) A health maintenance contract may require prior authorization as a condition of coverage for prosthetic devices.

_____ (g) A health maintenance contract shall only be required to provide coverage for the most appropriate medically necessary model that adequately meets the medical needs of the policyholder.

_____ The mandate applies to all policies, contracts, agreements, plans or certificates of insurance issued or delivered within the commonwealth on or after January 1, 2007, or upon renewal to all policies, contracts, agreements, plans or certificates of insurance in effect **before January 1, 2007.** [[Chapter 292 of the Acts of 2006 was approved effective September 7, 2006]

Scalp Hair Prosthesis for Cancer Patients

_____ According to M.G.L. c. 176G, § 4J, "[a] group health maintenance contract which provides coverage for any other prosthesis, shall provide coverage for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia; provided, however, that such coverage shall be subject to a written statement by the treating physician that the scalp hair prosthesis is medically necessary; and provided, further, that such coverage shall be subject to the same limitations and guidelines as other prostheses. Scalp hair prosthesis coverage pursuant to this section shall not exceed an amount of $350 per year." (See also Bulletin No. 98-09)

Insurance Coverage of Qualified Clinical Trials
(Except Medicare Supplement Plans or contracts purchased by a subscriber that is a church or qualified church-controlled organization)

_____ According to M.G.L. c. 176G, § 4P, "[a]ny individual or group health maintenance contract shall provide for the coverage of patient care services furnished pursuant to qualified clinical trials as defined in, and subject to the requirements and limitations of, section 110L of chapter 175 [of the Massachusetts General Laws]." According to M.G.L. c. 175, § 110L(b), "[a]ny policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall cover and reimburse for patient care services provided pursuant to a qualified clinical trial to the same extent as they would be covered and reimbursed if the patient did not receive care in a qualified clinical trial." (See also M.G.L. c. 176A, § 8X or M.G.L. c. 176B, § 4X, and Bulletin No. 02-13)

NON-DISCRIMINATION

Victims of Domestic Abuse. According to M.G.L. c. 176G, § 19, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a health maintenance contract based on information that an individual has been a victim of abuse, as defined by section one of chapter two hundred and nine A [of the Massachusetts General Laws]. No health maintenance organization subject to this chapter, and no officer or agent thereof, shall seek information that such person has been a victim of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. The practices prohibited under this section shall include not only those overtly discriminatory but also practices and devices which are fair in form but discriminatory in practice. Nothing in this section shall be construed as creating a special class of insureds who have been victims of abuse as defined by said section one of said chapter two hundred and nine A [of the Massachusetts General Laws]. Any violation of this section shall constitute an unfair method of competition or an unfair or deceptive act or practice in violation of chapters ninety-three A and one hundred and seventy-six D [of the Massachusetts General Laws]."

_____ **Please confirm that the carrier complies with this requirement.**

Genetic Testing and Privacy Protection. According to M.G.L. c. 176G, § 24, "[n]o health maintenance organization subject to this chapter, and no officer or agent thereof, shall cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount of payment of premium or rates charged, in the length of coverage or in any of the terms and conditions of a health maintenance contact based on genetic information as defined in this section. No health maintenance organization subject to the provisions of this chapter and no officer of agent thereof, shall require genetic tests or private genetic information, as defined in this section, as a condition of the issuance or renewal of a health maintenance contract. Any violation of this section shall constitute an unfair method of competition or deceptive act or practice in violation of chapters 93A and 176D." [also see Bulletin No. 00-16]

_____ **Please confirm that the carrier complies with this requirement.**

MANDATED COVERAGE FROM CERTAIN TYPES OF PROVIDERS

_____ **Licensed Mental Health Professional**. For the purposes of M.G.L. c. 176G, § 4M, a "licensed mental health professional" "shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist."

_____ **Certified Registered Nurse Anesthetist and Nurse Practitioner**. According to M.G.L. c. 176G, § 4, policies shall provide benefits "for services rendered by a certified registered nurse anesthetist or nurse practitioner designated as such certified registered nurse anesthetist or nurse practitioner by the board of registration in nursing pursuant to the provisions of section eighty B of chapter one hundred and twelve; provided, however, that the following conditions are met: (1) the service rendered is within the scope of the certified registered nurse anesthetist's license or the nurse practitioner's authorization to practice by the board of registration in nursing; and (2) the policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth."

_____ **Podiatrist.** According to M.G.L. c. 176G §1, "[a]ny individual who has entered into a group health maintenance contract that provides for any podiatric medical or surgical service which is within the lawful scope of practice of a licensed podiatrist, shall be entitled to such services whether the service is performed by a physician or licensed podiatrist, including authorized referral services on a nondiscriminatory basis."

_____ **Psychotherapist.** According to M.G.L. c. 175, § 110(H)(b), "[c]onsultants or treatment sessions furnished by a facility in this clause [for outpatient benefits] shall be rendered by a physician or psychotherapist fully licensed under the provisions of chapter one hundred and twelve [of the Massachusetts General Laws] who devotes a substantial portion of his time treating intoxicated persons or alcoholics. For the purposes of this clause 'psychotherapist'' shall mean a person fully licensed to practice medicine under the provision of said chapter one hundred and twelve and who devotes a substantial portion of this time to the practice of psychiatry."

TO BE PROVIDED TO THE OFFICE OF PATIENT PROTECTION
[211 CMR 52.16]

A carrier shall provide the following to the Office of Patient Protection at the same time the carrier provides such material to the Bureau of Managed Care:

_____ (1) A copy of every evidence of coverage and amendments thereto offered by the carrier.

_____ (2) A copy of the provider directory described in 211 CMR 52.15.

_____ (3) A copy of the materials specified in 211 CMR 52.14.

A carrier shall provide the following to the Office of Patient Protection by no later than April 1:

_____ (4) A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the carrier.

_____ (5) A report of the percentage of physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;

_____ (a) For the purposes of 211 CMR 52.16(5) carriers shall exclude physicians who have moved from one physician group to another but are still under contract with the carrier.

_____ (b) For the purposes of 211 CMR 52.16(5) "voluntarily terminated" means that the physician terminated its contract with the carrier.

_____ (c) For the purposes of 211 CMR 52.16(5) "involuntarily terminated" means that the carrier terminated its contract with the physician.

_____ (6) The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and

_____ (7) A report detailing, for the previous calendar year, the total number of

_____ (a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and

_____ (b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such insureds, which shall include, but need not be limited to, race, gender and age.

Please confirm the carrier complies with the above-noted requirements.

SMALL GROUP PRODUCTS [M.G.L. c. 176J and regulation 211 CMR 66.00]

_____ According to M.G.L. c. 176J §1, the term "Health benefit plan" is defined as "[a]ny individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; and an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G.

The term "health benefit plan" shall not include accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non- coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter."

Please confirm whether the filed plan is intended to be offered to individuals or groups with between one and fifty eligible employees.
YES____ NO____

If NO, please provide the legal basis why the filed plan is not subject to the above-noted statute and regulation within your cover letter.

If YES, please review Massachusetts small group law M.G.L. c. 176J and regulation 211 CMR 66.00 including guaranteed issue and guaranteed renewal requirements. Please review that law and include provisions as required. In addition, please identify the section(s) and page number(s) of the documents filed that address the following issues:

DEFINITIONS [M.G.L. c. 176J §1 and 211 CMR 66.04 (if used)]

_____ **Creditable coverage** "coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act."

_____ **Date of enrollment** "with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

_____ **Eligible dependent** "the spouse or child of an eligible individual or eligible employee, subject to the applicable terms of the health benefit plan covering such individual or employee."

_____ **Eligible employee** "an employee who: (1) works on a full-time basis with a normal work week of thirty or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business; and provided, however, that "eligible employee" does not include an employee who works on a temporary or substitute basis, and (2) is hired to work for a period of not less than five months."

_____ **Eligible individual** "an individual who is a resident of the commonwealth."

_____ **Eligible small business or group** "any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year, employed from among one to not more than fifty eligible employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than fifty employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a MEWA shall be subject to this chapter."

_____ **Emergency services** "services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(l)(B)."

_____ **Group health plan** "an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of this chapter, medical care means amounts paid for (i) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i); and (iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii). Any plan, fund or program which would not be, but for section 2721(e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to clause (a), as an employee welfare benefit plan which is a group health plan. In a group health plan, (a) the term "employer" also includes the partnership in relation to any partner; and (b) the term "participant" also includes:

(1) in connection with a group health plan maintained by a partnership, an individual who is a partner of the partnership; or

(2) in connection with a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the self-employed individual if that individual is, or may become, eligible to receive a benefit under the plan or that individual's beneficiaries may be eligible to receive any benefit."

_____ **Health benefit plan** "any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; and an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G. Health benefit plans shall not include: accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any

similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

_____ **Pre-existing conditions provision** "with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be a preexisting condition. Trade Act/HCTC-eligible personas shall not be subject to any pre-existing conditions provision.

_____ **Resident** "a natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident."

_____ **Trade Act/HCTC-eligible persons** "any eligible trade adjustment assistance recipient or any eligible alternative trade adjustment assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210."

GUARANTEE ISSUE/GUARANTEE RENEWABLE

Every carrier shall make available to every eligible individual and every small business, including an eligible small group or eligible individual a certificate that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents, every health benefit plan that it provides to any other eligible individual or eligible small business. No health plan may be offered to an eligible individual or an eligible small business unless it complies with this chapter. Upon the request of an eligible small business or an eligible individual, a carrier must provide that group or individual with a price for every health benefit plan that it provides to any eligible small business or eligible individual. Except under the conditions set forth in paragraph (3) of subsection (a) and paragraph (2) of subsection (b), every carrier shall enroll any eligible small business or eligible individual which seeks to enroll in a health benefit plan. Every carrier shall permit every eligible small business group to enroll all eligible persons and all eligible dependents; provided that the commissioner shall promulgate regulations which limit the circumstances under which coverage must be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than he was initially eligible to enroll in a group plan. **[M.G.L. c. 176J §4(a)(1)]**

_____

A carrier shall enroll any person who meets the requirements of an eligible individual into a health plan if such person requests coverage within 63 days of termination of any prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility. **[M.G.L. c. 176J §4(a)(2)]**

_____

A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan, but a carrier may only impose a preexisting condition exclusion for not more than 6 months or a waiting period, which shall be applied uniformly without regard to any health status-related factors, of not more than 4 months following the individual's effective date of coverage. If a policy includes a waiting period, emergency services shall be covered. In determining whether a pre-existing condition exclusion or a waiting period applies, all health plans shall credit the time such person was covered under prior creditable coverage if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage and if the previous coverage was reasonably actuarially equivalent to the new coverage. Coverage shall become effective within 30 days of the date of application. The commissioner shall promulgate regulations for pre- existing condition exclusions and waiting periods permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the HCTC; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.
[M.G.L. c. 176J §4(a)(3)]

_____

As of April 1, 2007, no policy may provide for any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage. **[M.G.L. c. 176J §4(a)(4)]**

_____

Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. The commissioner is authorized to promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this
_____ chapter. **[M.G.L. c. 176J §4(b)(1)]**

A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify
_____ the application for coverage under the health benefit plan. **[M.G.L. c. 176J §4(b)(2)]**

A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that:--

_____ (i) the small business fails at the time of issuance or renewal to meet a participation requirement established under the definition of participation rate in section 1; or

_____ (ii) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner. **[M.G.L. c. 176J §4(b)(3)]**

Notwithstanding any other provision in this section, a carrier may deny an eligible individual or an eligible small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or eligible small business enrolls through an intermediary or the connector. If an eligible individual or an eligible small business with 5 or fewer eligible employees elects to enroll through an intermediary or the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all similarly situated eligible individuals and eligible small
_____ businesses in a similar manner. **[M.G.L. c. 176J §4(b)(4)]**

Every health benefit plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996 as amended, or by regulations promulgated under that act.
_____ **[M.G.L. c. 176J §4(c)(1)]**

A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (i) has not paid the required premiums; (ii) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; (iii) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; (iv) fails, at the time of renewal, to meet the participation requirements of the plan; (v) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (vi) in the case of a

_____ group, is not actively engaged in business. **[M.G.L. c. 176J §4(c)(2)]**

A carrier may refuse to renew enrollment for an eligible individual, eligible employee or eligible dependent if: (i) the eligible individual, eligible employee or eligible dependent has committed fraud, misrepresented whether or not he or she is an eligible individual, eligible employee or eligible dependent, or misrepresented information necessary to determine his eligibility for a health benefit plan or for specific health benefits; or (ii) the eligible individual, eligible employee or eligible dependent fails to comply in a material manner with health benefit plan

_____ provisions. **[M.G.L. c. 176J §4(c)(3)]**

Nothing in this chapter shall prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the

_____ definition of eligible employee. **[M.G.L. c. 176J §4(d)**

INTERMEDIARY REQUIREMENTS [M.G.L. c. 176J §4(b)(4)]:

A carrier may deny an eligible individual or a group of five or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or the group enrolls through an intermediary or through the Connector,

Please confirm whether the carrier requires eligible individuals or groups of five or fewer

_____ **eligible employees enrolls through an intermediary or through the Connector.**

YES ___ NO____ If Yes, respond to the following:

A carrier may condition the enrollment of an individual and/or a group of five or fewer eligible persons on the group enrolling through an intermediary only if the intermediary has at least 30 days prior to enrolling eligible individuals and/or eligible small businesses filed with the commissioner two copies of a report that contains at least the following information certified by an officer of the organization in a format specified by the commissioner. **[211 CMR 66.13(3)(a)]**

_____ Please (1) provide a list of the name(s), address(es) and telephone number(s) of the intermediaries that the carrier requires eligible individuals or groups of five or fewer eligible employees to enroll and (2) certify that the carrier has confirm with the intermediary(ies) that the interemediary(ies) have filed to the Division as required by 211 CMR 66.13(3)(a) and 211 CMR 66.13(3)(b)**.**

ANNUAL ACTUARIAL OPINION [M.G.L. c. 176J §7]:

According to M.G.L. c. 176J §7(a)2, "[e]very carrier shall make reasonable disclosure to prospective small business insureds, as part of its solicitation and sales material of...(2) the participation requirements or participation rate adjustments of the carrier for each health benefit plan.

_____ **Please confirm that the carrier will comply with this requirement.**

According to M.G.L. c. 176J §7(b), "[e]very carrier, as a condition of doing business...on and after January 1, 2007, shall electronically file with the commissioner an annual actuarial opinion that the carrier's rating methodologies and rates to be applied in the upcoming calendar year comply with the requirements of this chapter and any regulations promulgated under the authority of this chapter...shall file electronically an annual statement of the number of eligible individuals, eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier."

In addition, [e]very carrier shall maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are under sound actuarial principles, and comply with this chapter. Such information shall be made available to the commissioner upon request, but shall remain confidential."

_____ **Please include (1) a certification stating when the annual actuarial opinion(s) were last filed with the Division (2) the class(es) of business filed and (3) the time period the opinion(s) encompassed.**

_____ According to M.G.L. c. 176J §7(c), "[e]very carrier shall notify the commissioner regarding any material changes or additions to the actuarial methodology at least 30 days before the effective date of the change or addition, including amendments to rate basis types, rating factors, intermediary relationships, distribution networks and products offered within this market. If the commissioner determines that a carrier is not complying with this chapter, the commissioner may disapprove the rating methodologies and the rates which the carrier uses.

Please confirm that the carrier will comply with this requirement.

INDIVIDUAL PROTECTIONS –

APPLICATION FORM - Application form must conform to requirements of M.G.L. c. 175I:

_____ Please confirm that the carrier is in compliance with M.G.L. c. 175I as well as the Federal HIPPA Privacy Notice [Title 45 of the Code of Federal Regulations ("CFR") Parts 160 and 164].

Form and Content of Policy Applications – [211 CMR 40.13]:
When a person uses an application form to be completed by the applicant as an offer to contract for an insured health plan, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with 211 CMR 40.13 the following guidelines as to the contents and applicability of disclosure requirements shall be used.

_____ 1. If the advertised or marketed policy contains a provision which allows the carrier to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy, the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in 211 CMR 40.07(3)(a).

[Pre-Existing Conditions - 211 CMR 40.07(3)(a).
A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used or it shall be considered misleading, and therefore prohibited.]

_____ 2. If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind, *e.g.* "fifth day for sickness" or of the one-time exclusionary kind, "30 day" or "six months for certain conditions," the application must disclose in negative terms the nature of such exclusion.

_____ 3. The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

_____ 4. The application must disclose the premium rate for the policy being solicited.

_____ 5. The application must disclose clearly and unambiguously the terms of renewability and premium guarantee, if any.

_____ At the completion of the above required statements of disclosure space shall be made for the applicant's signature acknowledging understanding of such disclosures.

211 CMR 42.08: Requirements for Replacement

_____ (1) Application forms must contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and sickness insurance currently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

_____ (2) An agent or carrier soliciting the sale, upon determining that the sale would involve replacement, must furnish to the applicant, at the time of taking the application, or before the policy is issued the notice described in 211 CMR 42.99. A copy of the notice must be left with or retained by the applicant and a signed copy must be retained by the carrier.

HMOs WITH INSURED PREFERRED PROVIDER PLANS

For newly filed Insured Preferred Provider Plans please be sure to file the appropriate checklist.

Definitions from M.G.L. c. 176I, § 1 and 211 CMR 51.02 (if used)

_____ **Preferred Provider**, "a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement."

_____ **Preferred Provider Arrangement ("PPA")** "a contract between or on behalf of an organization and a preferred provider that complies with all the applicable requirements of M.G.L. c. 152, c. § 30, c. 176I, and 211 CMR 51.00."

_____ **Preferred Provider Health Plan** "an insured health benefit plan offered by an organization that provides incentives for covered persons to receive health care services from preferred providers in the context of a preferred provider arrangement."

Insured Preferred Provider Plans in general as outlined in 211 CMR 51.04

_____ According to 211 CMR 51.04(2)(a), an insured preferred provider plan is to include "[a] narrative description of the preferred provider health plan to be offered, including a description of whether the plan will be available to small employers eligible under M.G.L. c. 176J."

_____ According to 211 CMR 51.04(1)(a), an insured preferred provider plan is to include "[a] description of the geographical area in which the preferred providers are located, including a map of the distribution of the preferred providers."

_____ According to 211 CMR 51.04(1)(b), an insured preferred provider plan is to include "[a] description of the manner in which covered health care services and other benefits may be obtained by persons using the preferred providers, including a description of the grievance system available to covered persons, including procedures for the registration and resolution of grievance and any requirement within a preferred provider health plan that covered persons select a gatekeeper provider."

_____ According to 211 CMR 51.04(2)(b)(3), an insured preferred provider plan is to include "[a] description of any provision for covered services to be payable at the preferred level until an adequate network has been established for a particular service or provider type."

_____ According to 211 CMR 51.04(2)(b)(5), an insured preferred provider plan is to include "[a] description of the incentives for covered persons to use the services of preferred providers."

_____ According to 211 CMR 51.04(2)(b)(6), an insured preferred provider plan is to include "[a] description of any provisions that allow covered persons to obtain covered health care services from a non-preferred provider at the benefit level for the same covered health care service rendered by a preferred provider."

_____ According to 211 CMR 51.04(2)(b)(7), an insured preferred provider plan is to include "[a] description of any provisions within the preferred provider health plan for holding covered

persons financially harmless for payment denials by, or on behalf of, the organization for improper utilization of covered health care services caused by preferred providers."

_____ According to 211 CMR 51.04(2)(c)(1), an insured preferred provider plan is to include "[a] description of the arrangements to be used by the organization to protect covered members from financial liability in the event of financial impairment or insolvency of any preferred provider that assumes financial risk."

Requirements of the Evidence of Coverage as outlined in 211 CMR 51.05

According to 211 CMR 51.05(2)(a)-(d), "[t]he evidence of coverage must also include the following in clear and understandable language:

_____ (a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;

_____ (b) Provisions that if a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for such care will be made at the same level and in the same manner as if the covered person had been treated by a preferred provider;

_____ (c) Benefit levels for covered health care services rendered by non-preferred providers must be at least 80% of the benefit levels for the same covered health care services rendered by preferred providers.

_____ 1. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a usual and customary charge, and not a percentage of the amount paid to preferred providers.

_____ 2. The 80% requirement shall be met if the coinsurance percentage for health care services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered health care services rendered by a preferred provider, excluding reasonable deductibles and copayments; and

_____ (d) A description of all benefits required to be provided by law in accordance with all of the provisions of the organization's enabling or licensing statutes."

Reporting Requirements as outlined in 211 CMR 51.06

_____ According to 211 CMR 51.06(1), "[e]ach organization with a preferred provider health plan or workers' compensation preferred provider arrangement shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to an evidence of coverage and significant changes to the lists of preferred providers." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 51.06(2), "[e]ach organization with a preferred provider health plan or a workers' compensation preferred provider arrangement shall on April 30th of each year file with the Commissioner a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner: (a) A summary of the number of covered persons; (b) A summary of the utilization experience of covered persons; and (c) A current provider directory that lists preferred providers by specialty and geographic area." **Please confirm that the carrier will comply with these requirements.**